Congressional Research Service
Informing the legislative debate since 1914

# Out-of-Pocket Costs for Medicaid Beneficiaries: In Brief

January 7, 2015

**Congressional Research Service**
https://crsreports.congress.gov
R43850

**CRS REPORT**
Prepared for Members and
Committees of Congress

# Summary

The federal Medicaid statute and accompanying regulations include provisions that states can apply to certain program beneficiaries with respect to out-of-pocket cost-sharing, including premiums that may be required on a monthly or quarterly basis, enrollment fees that may be applied on an annual or semiannual basis, and point-of-service cost-sharing (e.g., a co-payment to a Medicaid participating provider for a specific covered service received). To implement these options, states must submit Medicaid state plan amendments (SPAs) detailing these provisions to the federal Centers for Medicare and Medicaid Services (CMS) for approval. This report provides an overview of these federal authorities and includes some state-specific examples.

# Contents



## Tables



## Contacts

Medicaid is a means-tested entitlement program that, in FY2012, financed the delivery of primary and acute medical services, as well as long-term services and supports, to nearly 57 million people and cost states and the federal government a total of $431 billion.[1] Each state designs and administers its own version of Medicaid under broad federal rules. As a result, there is significant variation across states in terms of who is eligible for coverage, what services are available, and which subgroups of beneficiaries are subject to out-of-pocket costs. Cost-sharing requirements may include participation-related cost-sharing, such as monthly premiums or annual enrollment fees, as well as point-of-service cost-sharing such as co-payments—flat dollar amounts paid directly to providers for services rendered. Similar types of out-of-pocket cost-sharing can apply to individuals enrolled in private health insurance, although the amounts to which such beneficiaries may be subject can be higher than the amounts allowed in Medicaid.[2]

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA 1982, P.L. 97-248, Subtitle B) added to the federal Medicaid statute the authority for states to impose enrollment fees, premiums, or similar charges as well as point-of-service cost-sharing. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) made additional, major changes to cost-sharing requirements that could be applied to Medicaid beneficiaries, including allowing states to permit providers to deny services when a co-payment requirement is not met. In July 2013, the Centers for Medicare and Medicaid Services (CMS) issued new regulations for Medicaid premiums and cost-sharing.[3]

Today, participation-related cost-sharing (e.g., premiums) in Medicaid tends to be limited to certain subpopulations, and states use point-of-service cost-sharing more broadly. States can require certain beneficiaries to share in the cost of Medicaid services, but there are limits on (1) the amounts states can impose, (2) the beneficiary groups that can be required to pay, and (3) the services for which cost-sharing can be charged. In general, premiums and enrollment fees are often prohibited. However, premiums may be imposed on enrollees with income above 150% of the federal poverty level (FPL). A survey by the Kaiser Family Foundation found that in state fiscal year (SFY) 2013, 39 states had at least one group able to participate in Medicaid by paying a premium, with a total of 59 different premium programs.[4]

States can also impose point-of-service cost-sharing, such as co-payments, coinsurance, deductibles, and other similar charges, on most Medicaid-covered inpatient and outpatient benefits. However, they cannot impose cost-sharing for emergency services or family planning services and supplies. Some subgroups of beneficiaries are exempt from cost-sharing (e.g., children under 18 years of age and pregnant women). The cost-sharing amounts that can be charged vary with income. In SFY2013, 46 states (including the District of Columbia) reported

[1] For a general introduction to Medicaid, see the CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[2] For additional details about out-of-pocket costs for individuals with private health insurance, see CRS Report R42978, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*, by Evelyne P. Baumrucker and Bernadette Fernandez.

[3] See Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 *Federal Register*, July 15, 2013.

[4] Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, Kaiser Commission on Medicaid and the Uninsured, October 2013.

having co-payment requirements.[5] Higher beneficiary cost-sharing is allowed in certain circumstances, and federal regulations modified some of these provisions.[6]

Medicaid premiums and service-related cost-sharing incurred by all individuals in a Medicaid household cannot exceed an aggregate limit of 5% of family income applied on either a monthly or quarterly basis, as specified by the state Medicaid agency.[7] States can use either Medicaid state plan amendments (SPAs) or Section 1115 waiver authority in the Social Security Act to establish both premiums and point-of-service cost-sharing. This report includes examples of both types of beneficiary out-of-pocket spending in Medicaid.

Other federal regulations (issued October 1, 2013) address out-of-pocket costs for Medicaid beneficiaries enrolled in Medicaid managed care plans. State contracts with Medicaid managed care plans must follow the same federal regulations applicable under the state Medicaid plan, and they also must comply with specific regulatory requirements.[8]

# Participation-Related Cost-Sharing

To obtain health insurance, certain Medicaid enrollees may be subject to monthly premiums, the most common form of participation-related cost-sharing.[9] Such charges are prohibited under Medicaid for many eligibility subgroups.

Enrollment fees, premiums or similar charges must adhere to the following rules: a minimum charge of at least $1.00 per month is imposed on (a) one- or two-person families with monthly gross income of $150 or less, (b) three- or four-person families with monthly gross income of $300 or less, and (c) five- or more person families with monthly gross income of $350 or less.[10] Any charge related to gross family income that is above these minimums may not exceed the standards shown in **Table 1**:

**Table 1. Maximum Monthly Charge by Family Income and Size**

(in dollars)

| Gross Family Income (per month) | Family Size | | |
|---|---|---|---|
| | 1 or 2 People | 3 or 4 People | 5 or More People |
| $150 or less | 1 | 1 | 1 |
| $151 or $200 | 2 | 1 | 1 |
| $201 to $250 | 3 | 1 | 1 |
| $251 to $300 | 4 | 1 | 1 |
| $301 to $350 | 5 | 2 | 1 |
| $351 to $400 | 6 | 3 | 2 |
| $401 to $450 | 7 | 4 | 3 |

[5] Ibid.

[6] For additional details, see the source in footnote 3.

[7] Additional details describing limitations on both premiums and service-related cost-sharing are available at Title 42, §447.56 of the *Code of Federal Regulations* (C. F. R.).

[8] See 42 C.F.R. §447.52(h), and 42 C.F.R. §§447.50 - 447.57.

[9] Enrollment fees, another form of income-related charges, may also be used in Medicaid, but such fees are uncommon.

[10] See 42 C.F.R. 447.52(a).

| Gross Family Income (per month) | Family Size | | |
|---|---|---|---|
| | 1 or 2 People | 3 or 4 People | 5 or More People |
| $451 to $500 | 8 | 5 | 4 |
| $501 to $550 | 9 | 6 | 5 |
| $551 to $600 | 10 | 7 | 6 |
| $601 to $650 | 11 | 8 | 7 |
| $651 to $700 | 12 | 9 | 8 |
| $701 to $750 | 13 | 10 | 9 |
| $751 to $800 | 14 | 11 | 10 |
| $801 to $850 | 15 | 12 | 11 |
| $851 to $900 | 16 | 13 | 12 |
| $901 to $950 | 17 | 14 | 13 |
| $951 to $1,000 | 18 | 15 | 14 |
| More than $1,000 | 19 | 16 | 15 |

**Source:** Title 42, Chapter IV of the *Code of Federal Regulations* (C.F.R.: October 1, 2013 edition); 42 C.F.R. §447.52(b).

Different federal regulations apply to certain Medicaid subgroups for families with income exceeding 150% FPL (see **Table 2**). Except for premiums applicable to Medicaid beneficiaries classified as medically needy,[11] the state Medicaid agency may choose to terminate individuals' Medicaid coverage on the basis of failure to pay for 60 days or more.[12]

**Table 2** provides information about optional premiums that states can choose to apply to specific Medicaid subgroups with income that exceeds 150% FPL. For several of these subgroups, states are allowed to set premiums on a sliding scale based on family income. Other caveats apply to specific subgroups, also identified in this table. As of SFY2013, a total of 39 states indicated that at least one group participated in Medicaid by paying premiums, and 11 states and the District of Columbia did not require premiums under Medicaid.[13]

[11] In general, Medicaid beneficiaries fall into two classifications. *Categorically needy individuals* have low-incomes and are elderly, individuals with disabilities, children, pregnant women, parents, or non-elderly adults without dependent children. *Medically needy beneficiaries*, who have the same characteristics as categorically needy groups, have income that is too high to qualify as categorically needy, but also have some medical expenses. Medically needy coverage is particularly important for the elderly and persons with disabilities, because this Medicaid eligibility category allows deductions for medical expenses that lower the amount of income counted in the determination of financial eligibility for Medicaid. For additional information on medically needy beneficiaries, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by Kirsten J. Colello.

[12] As per 42 C.F.R. §447.55(b)(2).

[13] The 11 states are Alabama, Florida, Hawaii, New Jersey, New Mexico, New York, North Carolina, South Carolina, South Dakota, Tennessee, and Virginia. See *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, October 2013 at http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf.

**Table 2. Optional Premiums That May Apply to Specific Medicaid Subgroups with Family Income Exceeding 150% of the Federal Poverty Level (FPL)**

| Type of Beneficiary | Family Income Standard/Test | Applicable Premiums | Applicable Federal Regulations |
|---|---|---|---|
| Certain pregnant women | 151%-185% of the FPL after deducting child care expenses | Cannot exceed 10% of the amount by which family income exceeds 150% FPL after deducting child care expenses. State Medicaid agencies may use state or local funds from other programs to pay these premiums | 42 C.F.R. §447.55(a)(1) |
| Other pregnant women | Beneficiaries covered under a §1115 waiver as of March 23, 2010, or December 31, 2013, if the applicable income standard is higher when converted to the modified adjusted gross income (MAGI) equivalent standard[a] | Subject to state-specific terms and conditions of the waiver as approved by the Centers for Medicare and Medicaid Services | 42 C.F.R. §447.55(a)(1) |
| People between the ages of 16 and 64 who are classified as qualified severely impaired individuals who receive supplemental security income (SSI) payments (due to blindness or disability)<br>*or*<br>employed individuals with a medically improved disability whose assets, resources and earned or unearned income (or both) do not exceed limitations (if any) established by the state<br>*or*<br>individuals who qualify for Medicaid via the Ticket to Work and Work Incentives Act of 1999 | States define the income thresholds for each of these subgroups | May be charged premiums on a sliding scale based on income | 42 C.F.R. §447.55(a)(2) |

| Type of Beneficiary | Family Income Standard/Test | Applicable Premiums | Applicable Federal Regulations |
|---|---|---|---|
| Certain employed people with a medically improved disability between the ages of 16 and 64 whose assets, resources, and earned plus unearned income (or both) do not exceed applicable limitations (if any) established by the state | Highest income standard does not exceed state-established limits, if any | May be charged premiums on a sliding scale based on income | 42 C.F.R. §447.55(a)(2) |
| Certain children with disabilities under the age of 19 eligible for Medicaid through the Family Opportunity Act (P.L. 109-171, Chapter 6, Subchapter A) | Upper income limit is 300% FPL | May be charged premiums on a sliding scale based on income, applied on a monthly or quarterly basis; aggregate limits on premiums for such children and their families (if applicable) may not exceed 5% of family income among families with income up to 200% FPL or 7.5% of family income among families with income from 200% to 300% FPL | 42 C.F.R. §447.55(a)(3) |
| Certain qualified disabled and working individuals entitled to enroll in Medicare Part A (hospital benefits) who must not be otherwise eligible for Medicaid | Upper income limit is less than 200% FPL; other financial tests (such as asset tests) may be applied | May be charged premiums at state option | 42 C.F.R. §447.55(a)(4) |
| Individuals classified as medically needy[b] | Upper income limit is at state-specified thresholds | May be charged premiums on a sliding scale; the state Medicaid agency must impose an appropriately higher charge for each higher level of income, not to exceed $20 per month for the highest level of family income | 42 C.F.R. §447.55(a)(5) |

**Source:** Congressional Research Service compilation based on selected C.F.R. information.

a. Defined as the Internal Revenue Code's adjusted gross income (reflecting certain deductions such as trade and business deductions, losses from sale of property, and alimony payments) increased (if applicable) by tax-exempt interest and income earned by U.S. citizens or residents living abroad. The definition of income for Medicaid eligibility includes nontaxable Social Security benefits.

b. In general, Medicaid beneficiaries fall into two classifications. *Categorically needy individuals* have low-incomes and are elderly, individuals with disabilities, children, pregnant women, parents, or other non-elderly adults. *Medically needy* beneficiaries have the same characteristics as categorically needy groups but have income that is too high to qualify as categorically needy. However, they also have some medical expenses. Medically needy coverage is particularly important for the elderly and persons with disabilities because this Medicaid eligibility category allows deductions for medical expenses that lower the amount of income counted in the determination of financial eligibility for Medicaid. For additional information on medically needy beneficiaries, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by Kirsten J. Colello.

# Service-Related Cost-Sharing

Beneficiary out-of-pocket payments to providers at the time of service can take three forms. A *deductible* is a specified dollar amount paid for certain services rendered during a specific time period (e.g., per month or quarter) before health insurance (e.g., Medicaid) begins to pay for care. *Coinsurance* is a specified percentage of the cost or charge for a specific service delivered. A *co-payment* is a specified dollar amount for each item or service delivered. Deductibles and coinsurance are infrequently used in Medicaid, but co-payments are applied to some services and groups.

Federal rules place limits on which services cost-sharing can be applied to (including which specific services are exempt, discussed below) and what amounts can be charged. Cost-sharing can be charged for allowed services regardless of income, but the maximum amount can be substantially higher for individuals with incomes greater than 100% FPL. **Table 3** provides a comparison of the maximum charges allowed for service-related cost-sharing applicable to outpatient services and inpatient stays for three family income subgroups.

**Table 3. Maximum Allowable Cost-Sharing for Outpatient Services and Inpatient Stays by Family Income**

| | Maximum Allowable Cost-Sharing | | |
|---|---|---|---|
| **Services** | **Individuals with Family Income ≤ 100% FPL** | **Individuals with Family Income Between 101% and 150% FPL** | **Individuals with Family Income > 150% FPL** |
| Outpatient Services (physician visit, physical therapy, etc.) | $4 | 10% of the cost the state Medicaid agency pays | 20% of the cost the state Medicaid agency pays |
| Hospital Inpatient Stay | $75 | 10% of the cost the state Medicaid agency pays | 20% of cost the state Medicaid agency pays |

**Source:** Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 *Federal Register* 42308, July 15, 2013.

**Notes:** FPL means federal poverty level. The information in this table applies to state Medicaid plans. Other cost-sharing provisions may apply to state-specific waiver programs. Outpatient services include all such services except those explicitly exempted. For more details, see below. States with cost-sharing for inpatient stays that exceeds $75 per stay as of July 15, 2013 must submit a plan to CMS to reduce inpatient cost-sharing to $75 on or before July 1, 2017 (as per 42 C.F.R. §447.52(b)(2)).

**Table 4** provides a comparison of maximum allowable charges for service-related cost-sharing for prescription drugs (preferred and non-preferred) as well as nonemergency use of an emergency department, also based on family income. Some services are exempt from co-payments, including, for example, emergency use of emergency departments.

**Table 4. Maximum Allowable Cost-Sharing for Prescription Drugs and Nonemergency Use of the Emergency Department by Family Income**

| Services | Maximum Allowable Cost-Sharing | |
|---|---|---|
| | Individuals with Family Income ≤ 150% FPL | Individuals with Family Income > 150% FPL |
| Preferred Drugs | $4 | $4 |
| Non-preferred Drugs | $8 | 20% of the cost the state Medicaid agency pays |
| Nonemergency Use of the Emergency Department | $8 | No limit |

**Source:** HHS, CMS, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment," 78 *Federal Register* 42309, July 15, 2013.

**Notes:** FPL means federal poverty level. Preferred drugs are included on a state's formulary. A formulary, also known as a preferred drug list (PDL), is a cost and utilization control mechanism authorized under federal Medicaid law. States use pharmacy and therapeutics committees composed of medical and pharmacological experts to identify drugs they will include on their PDLs. States generally negotiate PDL drug price concessions from drug manufacturers above statutory rebates. Thus, state and federal Medicaid expenditures are reduced by using PDLs. Non-preferred drugs are still available to Medicaid beneficiaries, although these drugs may be subject to higher cost-sharing, prior authorization, or both. Prior authorization requires that health care providers obtain permission from the Medicaid program or, more often a contractor hired by the Medicaid agency, prior to dispensing drugs to beneficiaries. The information in this table applies to state Medicaid plans. Other cost-sharing provisions may apply to state-specific waiver programs. Although there is no limit on cost-sharing for individuals with income above 150% FPL for nonemergency use of an emergency department, the aggregate cap on out-of-pocket costs also applies to nonemergency use of an emergency department.

Apart from point-of-service cost-sharing for drugs and nonemergency services provided in an emergency department (described in **Table 4**), federal regulations specify that the maximum allowable cost-sharing dollar amounts will increase annually, beginning October 1, 2015, for certain Medicaid enrollees. Specifically, for individuals with income at or below 100% FPL, the maximum allowable cost-sharing amounts must increase each year by the percentage increase in the medical care component of the consumer price index for all urban consumers (CPI-U) for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment.[14]

# Optional Targeted Cost-Sharing for Specific Medicaid Subgroups

Federal Medicaid regulations allow states to target cost-sharing to specific subgroups. For example, the state Medicaid agency may apply cost-sharing to specific groups with family income above 100% FPL.[15] The state Medicaid agency also may target cost-sharing to specified groups of individuals regardless of income for non-preferred drugs and for nonemergency services provided in a hospital emergency department.[16]

In states without fee-for-service payment rates, individuals at any income level may not be subject to cost-sharing that exceeds the maximum amounts established for individuals with

[14] As per 42 C.F.R. §447.52(b)(1).

[15] As per 42 C.F.R. §447.52(d)(1).

[16] As per 42 C.F.R. §447.52(d)(2).

income at or below 100% FPL for both inpatient and outpatient services and at or below 150% FPL for outpatient services, inpatient stays, prescribed drugs, and nonemergency use of the emergency department (i.e., the co-payment rates by type of service and family income as shown in **Table 3** and **Table 4**). In no case can the maximum cost-sharing established by the state be equal to or exceed the amount the state Medicaid agency pays for both inpatient and outpatient services.[17]

Certain Medicaid subgroups and specific Medicaid services are exempt from the application of deductibles, coinsurance, co-payments, or similar charges. Such subgroups include individuals classified as either categorically needy or medically needy who are children under the age of 18 (or up to the age of 21 at state option); certain pregnant women for services related to the pregnancy or to any other medical conditions that may complicate the pregnancy; and certain institutionalized individuals who are required to spend all but a minimal amount of their income required for personal needs.[18]

Federal statute and regulations prohibit states from requiring out-of-pocket costs for the following exempted services:

- emergency services (e.g., both inpatient and outpatient services furnished by a qualified provider) that are needed to evaluate or stabilize an emergency medical condition;[19]
- family planning services and supplies for individuals of childbearing age[20] including contraceptives and pharmaceuticals for which the state claims or could claim a 90% federal share of the total cost;[21]
- preventive services, including well-baby and well-child care services in either the managed care or fee-for-service delivery systems;[22]
- pregnancy-related services;[23]
- provider-preventable services (e.g., health care acquired conditions).[24]

Based on data from the same Kaiser Family Foundation survey noted above, 46 states[25] (including the District of Columbia) required co-payments in SFY2013. Five states (Hawaii, Nevada, New Jersey, Rhode Island and Texas) had no co-payment requirements. Two states indicated that co-payments were enforceable (e.g., providers are allowed to deny services when a co-payment requirement is not met). In Arkansas, such enforceability applies to co-payments for adults with income over 100% FPL (pending waiver approval). Maine plans to make pharmacy co-payments enforceable for those with income over 100% FPL. In addition, Maryland will end

[17] As per 42 C.F.R. §447.52(c).

[18] As per 42 C.F.R. §447.53(b).

[19] As per 42 C.F.R. §438.114(a) and §1932(b)(2)(i).

[20] As per 42 C.F.R. §447.56(a)(2)(ii) and §1905(a)(4)(C).

[21] As per §1903(a)(5).

[22] As per 42 C.F.R. §447.56(a)(2)(iii) and 42 C.F.R. §457.520.

[23] As per 42 C.F.R. §447.56(a)(2)(iv).

[24] As per 42 C.F.R. §447.56(a)(2)(v) and 42 C.F.R. §447.26(b).

[25] See *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, October 2013 at http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf.

co-payment enforceability for a waiver group as it transitions to the Patient Protection and Affordable Care Act (ACA; P.L. 111-148 as amended) expansion coverage.

Another Kaiser Family Foundation report noted that, in January 2013, non-zero co-payment amounts for non-preventive physician visits applicable to children in families with income at 151% FPL ranged from a low of $0.50 in Georgia to a high of $25 in Utah and Texas. Higher co-payment amounts for a non-preventive physician visit applied to children in families with income at 201% FPL and ranged from a low of $0.50 in Georgia to a high of $25 in Utah and Texas. In addition, a co-payment amount equal to 10% of the cost of a non-preventive physician visit applied to children in families with income at 201% FPL in Louisiana.[26]

# Beneficiary Subgroups Not Subject to Premiums or Point-of-Service Cost-Sharing

Specific Medicaid subgroups are exempt from out-of-pocket costs, including (1) certain children, (2) pregnant women, (3) individuals in nursing homes or who receive services provided in home and community-based settings, (4) terminally ill individuals receiving hospice care, (5) Indians who receive care through Indian health care providers or through what is called contract health services, and (6) individuals with breast or cervical cancer. Exclusions from the application of both premiums and point-of-service cost-sharing[27] are identified in **Table 5** below.

**Table 5. Beneficiaries Not Subject to Out-of-Pocket Costs**

| Type of Beneficiary | Applicable Federal Regulations |
|---|---|
| Certain children under the age of 19 eligible for Medicaid | 42 C.F.R. §435.118 and 42 C.F.R. §447.56(a)(1)(i) |
| Infants under the age of 1 in families with income up to 150% FPL for premiums and up to 133% FPL for cost-sharing; states may also elect to prohibit premiums and cost-sharing for infants in families with income up to 185% FPL | 42 C.F.R. §435.118 and 42 C.F.R. §447.56(a)(1)(ii) |
| Other children under the age of 18 receiving cash assistance through the Supplemental Security Income (SSI) program due to blindness or a qualifying disability, as well as children in states using more restrictive requirements for Medicaid than apply to SSI, and children ineligible for SSI or optional state supplements because of requirements that do not apply to Medicaid | 42 C.F.R. §447.56(a)(1)(iii); additional details regarding such excluded individuals are provided in 42 C.F.R. §435.120 through §435.122 and 42 C.F.R. §435.130 |

[26] As per Table 19 in *Getting Into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013* at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf.

[27] Described in 42 C.F.R. §447.56(a) and related regulations identified in the second column of **Table 5**.

| Type of Beneficiary | Applicable Federal Regulations |
|---|---|
| Children for whom child welfare services are available under Title IV-B of the Social Security Act (Child and Family Services) who are in foster care, and other youth receiving benefits under Title IV-E of the Social Security Act (Federal Payments for Foster Care and Adoption Assistance) without regard to age | 42 C.F.R. §447.56(a)(1)(iv) |
| Certain individuals under the ages of 19, 20 or 21 at state option | 42 C.F.R. §447.56(a)(1)(v) |
| Certain disabled children who qualify for Medicaid via the Family Opportunity Act (P.L. 109-171) may *not* be subject to point-of-service cost-sharing, but may be subject to premiums | 42 C.F.R. §447.56(a)(1)(vi) |
| Out-of-pocket expenses for pregnant women are not permitted except for premiums for pregnant women with incomes above 150% FPL and cost-sharing for services specified as not pregnancy-related | 42 C.F.R. §447.56(a)(1)(vii) |
| Individuals receiving care in an institution or at state option in a home and community-based setting whose income is reduced by amounts reflecting available income apart from amounts required for personal needs[a] | 42 C.F.R. §447.56(a)(1)(viii) |
| Certain terminally ill individuals who voluntarily elect to receive hospice care for a period of time established by the states | 42 C.F.R. §447.56(a)(1)(ix) |
| Indians who receive items or services from an Indian health care provider or through referral under contract health services are exempt from premiums and point-of-service cost-sharing | 42 C.F.R. §447.56(a)(1)(x) |
| Certain individuals who receive Medicaid in states that have elected to extend coverage to those with breast or cervical cancer | 42 C.F.R. §447.56(a)(1)(xi) |

**Source:** Congressional Research Service compilation based on selected C.F.R. information.

**Notes:** FPL means federal poverty level.

a. Another set of Medicaid rules applies to the treatment of income after a person has become eligible for coverage and either is living in an institution, such as a nursing facility, or is receiving Section 1915(c) home and community based waiver services while living in the community. These rules are commonly referred to as the post-eligibility treatment of income (PETI). In general, beneficiaries qualifying through certain eligibility groups are required to apply their income that exceeds specified amounts toward the cost of their care. Within federal guidelines, a beneficiary may retain a certain amount of income for personal use based on the services received. The amounts a beneficiary may retain vary by care setting. For additional information about PETI in Medicaid, see CRS Report R43506, *Medicaid Financial Eligibility for Long-Term Services and Supports*, by Kirsten J. Colello.

# Public Notification Requirements Regarding Beneficiary Out-of-Pocket Cost Obligations

Federal regulations[28] delineate beneficiary and public notice requirements related to out-of-pocket costs for Medicaid beneficiaries. The state Medicaid agency must provide a public schedule describing current premiums and other cost-sharing requirements, including (1) individuals who are subject to premiums or cost-sharing along with the current amounts; (2) the mechanisms for making payments for required premiums and cost-sharing charges; (3) the consequences for applicants or recipients who do not pay a premium or cost-sharing charge; (4) a list of hospitals charging cost-sharing for nonemergency use of the emergency department; and (5) a list of preferred drugs or a mechanism to access such a list, including the state Medicaid agency website.

Finally, state Medicaid agencies must make the public schedule available to a number of subgroups in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to such a notice. For beneficiaries, this information must be made available at the time of enrollment or reenrollment subsequent to the redetermination of Medicaid eligibility. It must also be made available when premiums, service-related cost-sharing charges, or aggregate limits are revised. For applicants, this information must be available at the time of application. The general public must also have access to this information. When a state wishes to establish or substantially modify existing premiums or cost-sharing, or to change the consequences for nonpayment, the agency must provide the public with advance notice of the state plan amendment (SPA), specifying the amount of premiums or cost-sharing and who will be subject to these charges. The agency must also provide a reasonable opportunity to comment on such SPAs, and it must submit documentation with the SPA to demonstrate that these requirements are met. If premiums or cost-sharing are substantially modified during the SPA approval process, the agency must provide additional public notice.

## Author Information

Evelyne P. Baumrucker
Specialist in Health Care Financing

## Acknowledgments

This report was written by Elicia J. Herz, who is no longer at CRS.

[28] As per 42 C.F.R. §447.57.

## Disclaimer